LETTERS

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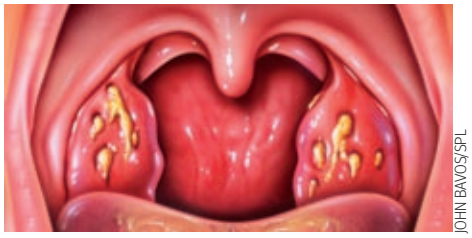

JOHN BAVOSI/SPL

RECURRENT PHARYNGO-TONSILLITIS

Time to stop doing tonsillectomies?

Alho et al conclude: "Tonsillectomy is an effective alternative for adults with a documented history of recurrent episodes of pharyngitis,"[1] but this assertion is unsupported by the evidence presented.

For those who had the early operation, the combined time with a sore throat including the operation was four days greater than for those whose operation was deferred.

People who were offered early tonsillectomy had fewer swabs taken than people given late tonsillectomy (5/36 *v* 20/34, P<0.0001). Yet, in the people who took swabs, there was little difference between positivity rates for group A streptococcal infection (1/5 samples (intervention) *v* 8/20 (control), P>>0.1).

The authors also say: "A substantial improvement over time in the rate of episodes of pharyngitis occurred in the control group during the follow-up, probably because of the natural course of the disease."[1] Isn't this the point? Recurrent tonsillitis tends to get better over time.

What this paper also shows is that a proper surgical control is required to test established surgical techniques. The absence of surgery, or delayed surgery, just does not pass scientific muster. But would people consent to a sham technique?

The NHS continues to do around 40 000 tonsillectomies in adults and children each year. Current research evidence of benefit is weak. Until the position is clearer, isn't there an argument to stop offering this intervention routinely on the NHS for recurrent tonsillitis outside of a properly conducted clinical study?

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Competing interests: None declared.

1 Alho OP, Koivunen P, Penna T, Teppo H, Koskela M, Luotonen J. Tonsillectomy versus watchful waiting in recurrent streptococcal pharyngitis in adults: randomised controlled trial. *BMJ* 2007;334:939-41. (5 May.)

More advice to clinicians

Concerns over the safety of single use instruments led to a moratorium in Wales on tonsillectomy, which created a cohort of patients who fulfilled the criteria for tonsillectomy but were denied surgery for more than one year.[1]

We think that adults presenting with chronic or recurrent tonsillitis[2] may expect as many as three or more episodes in the forthcoming six months and that these episodes are likely to result in time off work and further visits to the general practitioner. In contrast to the likely effect of intervention by tonsillectomy, we would not be able to give these patients any indication of if, or when, this was likely to change.

No randomised controlled trials have been conducted that support tonsillectomy in adults, but equally there are no studies that support denial of tonsillectomy as an alternative in patients with serious disease. As no test exists to determine if an individual patient will improve with time, "watchful waiting" is used by most clinicians as a diagnostic tool to determine whether surgery should be advised. Waiting is not a treatment in itself, and considerable morbidity may be associated with this option in some patients.

Ideally, a large scale randomised controlled trial with long term follow-up is required to examine the consequences of denying tonsillectomy to patients who previously would have been considered worthy of surgery. However, such a study may fail through lack of patient willingness to remain long enough in the control group. Furthermore, given the levels of morbidity measured in these patients and the large volumes of complaints we received from distressed patients and parents who were denied surgery, such a study may even be considered unethical.

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Competing interests: None declared.

1 Fox R, Tomkinson A, Myers P. Morbidity in patients waiting for tonsillectomy in Cardiff: a cross sectional study. *J Laryngol Otol* 2006;120:214-8.
2 Little P. Recurrent pharyngo-tonsillitis. *BMJ* 2007; 334:909. (5 May.)

OLDER PEOPLE IN CARE HOMES

Role of primary care

Practical steps taken in primary care can improve the standard of care for older people in care homes.[1] Seven years ago I presented an alternative to the reactive ("firefighting") approach to patients in care homes to my partners. Since then we have taken personal responsibility for a care home each, managing the long term health issues of our patients and building constructive relationships with the staff and management at the six homes (142 patients) we look after.

I have also presented the general practitioners in Peterborough with the arguments in favour of a named general practitioner from a committed practice taking on responsibility for the care of all the patients in a particular care home. Historically in Peterborough, patients have not changed doctor on entering a care home. This has resulted in practices with small numbers of patients in as many as 17 different care homes across the city, and care homes needing to liaise with up to 70 doctors in 17 different practices.

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Competing interests: None declared.

1 McMurdo MET, Witham MD. Health and welfare of older people in care homes. *BMJ* 2007;334:913-4. (5 May.)

How to bring about changes

McMurdo and Witham bring to mind the poor level of care that so many elderly people have to tolerate in residential care.[1] We underestimate how stressful it is for nurses and care assistants to provide intimate, personal care non-stop, day in day out, week after week. Unlike junior doctors, they are generally not on an upward career track. Stress may be measured by how strongly it is avoided, and staff turnover is an enormous problem in care of the elderly.

A more subtle emotional avoidance also occurs when interactions are carried out in a forced cheery manner, ensuring everything is kept at a superficial level. Nurses simply are not provided with sufficient resources to take on all their patients' problems.

There are some shining examples of good practice in various areas of health care. For example, when I asked, Action on Elder Abuse was unable to find any reports of abuse or neglect from hospices in the United Kingdom. We desperately need to learn from these examples. We also require urgent investment at the ward sister, matron, head of home level so that these people become the clinical heroes who can protect, inspire, and lead their staff in the Sisyphean task of long term care of elderly people.

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Competing interests: None declared.

1 McMurdo MET, Witham MD. Health and welfare of older people in care homes. *BMJ* 2007;334:913-4. (5 May.)

DIPYRIDAMOLE WITH ASPIRIN

Combination shows no advantage over aspirin alone

I disagree with Sudlow's recommendations.[1] The cited ESPRIT study had lots of limitations. Firstly, during the study inclusion criteria changed from a three arm to a two arm design.[2 3] Secondly, patients and physicians were not blinded to the treatment regimen. The resulting confounder therefore cannot be estimated. Thirdly, possible lifestyle changes, comorbidity, and co-treatment were not under examination.

Adherence in the dipyridamole-aspirin group was much less (2.6-fold) than in the aspirin group. The on-treatment analysis showed only a small benefit for bleeding complications (hazard ratio 0.58, 95% confidence interval 0.35 to 0.97). The analysis by intention to treat showed small benefits only in combined end points, which was driven by the single benefit in the occurrence of non-fatal strokes. The combined treatment showed no advantage in death. The new occurrence of disability was not reported. The real benefit from a number needed to treat of 104 is small.[4]

In my view the published data of ESPRIT do not alter the recommendations of the Antithrombotic Trialists' Collaboration.[5]

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Competing interests: None declared.

1 Sudlow C. Give dipyridamole with aspirin instead of aspirin alone to prevent vascular events after ischaemic stroke or TIA. *BMJ* 2007;334:901. (28 April.)
2 De Schryver ELLM, on behalf of the European/Australian stroke prevention in reversible ischaemia trial (ESPRIT) group. Design of ESPRIT: an international randomized trial for secondary prevention after non-disabling cerebral ischaemia of arterial origin. *Cerebrovasc Dis* 2000;10:147-50.
3 De Schryver ELLM. ESPRIT: Protocol changes. *Cerebrovasc Dis* 2001;11:286.
4 Tirschwell D. Aspirin plus dipyridamole was more effective than aspirin alone for preventing vascular events after minor cerebral ischemia. *ACP Journal Club* November/December 2006;145:57.
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ß BLOCKERS

Misuse of confidence intervals threatens conclusions

The data presented in table 1 of Ong's review leave considerable uncertainty about whether atenolol is better or worse than other ß blockers.[1] The confidence intervals for the results on other β blockers are wide (as fewer patients have been studied), and the test for interaction shows that the relative risk for atenolol, compared with other β blockers, for stroke is 1.05 (95% confidence interval 0.26 to 4.17), for myocardial infarction 1.22 (0.91 to 1.63), and for total mortality 1.21 (0.95 to 1.14). All of these confidence intervals include the possibility of no difference, and for stroke the results are compatible with atenolol being four times better or four times worse than other β blockers. It is very misleading to draw conclusions based on whether significance is achieved with either treatment alone.[2]

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Competing interests: None declared.

1 Ong HT. β blockers in hypertension and cardiovascular disease. *BMJ* 2007;334:946-9. (5 May.)
2 Altman DG, Bland JM. Interaction revisited: the difference between two estimates. *BMJ* 2003;326:219.

DRUG MONEY FOR PATIENT GROUPS

Cancerbackup responds

Mintzes says that Cancerbackup does not list the possible side effects of trastuzumab or say where its funding comes from—this is not the case.[1]

Cancerbackup provides up to date and accurate information about treatment including all possible side effects, both on our website (www.cancerbackup.org.uk) and in our factsheets.

We provide a full list on our website and now in our press releases of all funders.

We are advised by an independent clinical advisory board. Pharmaceutical companies have no influence on any decision we take.

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Competing interests: None declared.

1 Mintzes B. Should patient groups accept money from drug companies? No. *BMJ* 2007;334:935. (5 May.))

The illusion of invulnerability

Kent claims that patient groups are not naive, value their independence fiercely, and are quite capable of spotting the strings that may be attached to funding.[1] Many doctors have similar overconfident beliefs about invulnerability to being misled by drug companies.[2] This illusion of invulnerability actually increases vulnerability.[3]

In the 1840s doctors did not understand the risk of invisible microbes so were offended by the suggestion they should wash their hands. We are now going through a similar paradigm shift towards understanding the risk of invisible unintended bias from exposure to industry influence techniques. These techniques include manipulation of reciprocal obligation, which can occur without our awareness.[4] Patient groups tend to reciprocate by lobbying governments to pay for overpriced drugs rather than lobbying the companies to reduce their prices.

Funding for patient groups could be increased and the alleged problems with government funding reduced by abolishing patents to allow price competition and using the savings to fund research, education, health promotion, and other activities of patients' groups through competitive grants.[5]

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2 Mansfield PR, Lexchin J, Wen LS, Grandori L, McCoy CP, Hoffman JR, et al. Educating health professionals about drug and device promotion: advocates' recommendations. *PLoS Med* 2006:3(11):e451. http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371%2Fjournal.pmed.0030451
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4 Dana J, Loewenstein G. A social science perspective on gifts to physicians from industry. *JAMA* 2003;290:252-5.
5 Mansfield P. Industry-sponsored research: a more comprehensive alternative. *PLoS Med* 2006;3: e463. http://medicine.plosjournals.org/perlserv/?request=get- document&doi=10.1371/journal.pmed.0030463